NOTICE OF A COBRA-RELATED EVENT

Attn: Plan Administrator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the Plan Administrator of the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) of the occurrence of a qualifying event or other COBRA-related event. Notice is being provided in order to preserve the COBRA continuation coverage rights of the undersigned and all related qualified beneficiaries/covered dependents who are or were covered under the EUTF's group health plan(s).

The following COBRA-related event occurred on _____ :
[enter date in mm/dd/yyyy format]

☐ divorce of the covered employee and covered spouse

☐ legal separation of the covered employee and covered spouse

☐ a covered dependent child ceased to be a dependent under the terms of the EUTF's plan(s)

☐ a 2nd qualifying event occurred after a qualified beneficiary has become entitled to COBRA with a maximum coverage period of 18 or 29 months; the 2nd qualifying event was: _____
_____

☐ after electing COBRA, a qualified beneficiary became covered under another group health plan

☐ after electing COBRA, a qualified beneficiary became entitled to coverage under Medicare (Part A, Part B, or both)

☐ the Social Security Administration determined that a qualified beneficiary with a maximum COBRA coverage period of 18 months was totally disabled at any time during the first 60 days of COBRA coverage

☐ the Social Security Administration determined that a qualified beneficiary previously determined to be disabled is no longer disabled

The following individuals/qualified beneficiaries covered under the EUTF's plan(s) are affected by this event:

_____
_____
_____
_____

Documentation of the event including the date of its occurrence is attached. Please take the appropriate steps to enable the qualified beneficiaries affected by this event to exercise their COBRA continuation coverage rights.

_____ _____
Signature Date

_____ _____
Name of Covered Employee Telephone Number

_____ _____
Mailing Address City, State, Zip Code

Keep a copy of the completed form for your records.

Instructions for Completing the"Notice of a COBRA-Related Event"

The person completing this form should do the following:

1. Complete the form using blue or black ink. Do not use pencil. Write or print legibly.

2. Fill in the date that the event you are reporting occurred. Either show the date in full, for example, April 5, 2005 or use a month/day/year format, for example, 4/5/2005.

3. Check the box corresponding to the qualifying event or other COBRA-related event you are reporting. If none of the boxes apply, call the Plan Administrator at (808) 586-7390 for assistance.

4. List the names of all family members who (1) are or were covered under the Plan and (2) whose coverage under the Plan may be affected by the event you are reporting. Be sure to include your own name if it is appropriate.

5. Be sure to sign and date the form. Make a copy of the completed form and keep it in a safe place.

6. Indicate the name of the employee covered under the Plan. Show the employee's first name, middle initial and last name. Be sure to write or print legibly.

7. Indicate a current telephone number where the Plan Administrator may call you if there are any questions regarding your Notice.

8. Indicate the current mailing address where the Plan Administrator should send the COBRA Election Form or other correspondence. If you are reporting an event that affects the coverage of any family member who does not reside with you (for example, a child away at school), please note their current mailing address on the back of the form.

9. **Attach appropriate documentation to verify the date of the event you are reporting.** The "COBRA Notice" on the Plan's website provides examples of appropriate documentation for the different events. Call the Plan Administrator at (808) 586-7390 if you have any questions regarding the documentation you should provide.

10. Review the form to make sure it is complete. If you have any questions about completing the form, call the Plan Administrator at (808) 586-7390.

11. Return the completed form to the Plan Administrator at the address shown on the top of the Notice. You may return the Notice by mail, by fax, or you may deliver it by hand. You may fax the Notice to the Plan Administrator at (808) 586-2161. You may hand-deliver the Notice to the Plan Administrator at 201 Merchant Street, Suite 1520, Honolulu, HI.

12. If you mail the Notice, be sure to affix sufficient postage to the envelope. If the Postal Service returns your Notice because of insufficient postage, you may not be able to re-mail the notice in a timely manner. If your Notice is late, you will forfeit your rights under COBRA and you will not be entitled to elect or extend COBRA continuation coverage.

13. If you fax the Notice, be sure to keep a copy of the fax transmittal report showing the date and time the Notice was transmitted, the fax number that received the Notice and the status of the fax transmission.